aetna®
American Continental Insurance Company
An Aetna Company
800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067

Application for Whole Life Insurance
from American Continental Insurance Company

- Print clearly and use blue or black ink.
- Use Section 4 for additional remarks, requests, or explanations.

1. Proposed insured information

Full name of proposed insured *First, M.I., Last*

Address | Phone

City | State | Zip

E-mail | Social Security Number

Write the date of birth that is on the birth certificate.

Birth date *mm/dd/yyyy* | Age

Height *Feet and inches* | Weight *Pounds* | ○ Male ○ Female

Are you a legal resident of the United States? ○ Yes ○ No

Have you used any form of tobacco in the past 12 months? ○ Yes ○ No

2. Benefits, beneficiary and owner information

Initial amount of insurance applied for:
$

Plan requested:
○ Modified benefit plan
○ Graded benefit plan
○ Level benefit plan

Riders requested (if available):

If a nonforfeiture option is not selected, extended term insurance is the default.

Nonforfeiture options:
○ Automatic premium loan
○ Paid-up insurance
○ Extended term insurance

Amount paid with this application:
$

You have a choice of four payment modes for paying your premium. The Company does not charge you more based on the premium mode you select. There may be reasons, such as the time value of money, you would want to consider in making a decision on which premium mode to choose. Your agent can explain the differences in modes and help you decide which is best for you.

Payment mode:
○ Annually ○ Semi-Annually
○ Quarterly ○ Monthly EFT (Electronic Funds Transfer)

Full name of primary beneficiary *First, M.I., Last* | Relationship to insured

Contingent beneficiary *First, M.I., Last* | Relationship to insured

Does the proposed insured currently have any life insurance or annuity in force? ○ Yes ○ No

Will insurance applied for in this application replace, reduce or modify premiums paid for any existing life insurance or an annuity in force? ○ Yes ○ No

If the answer to either question is "yes", please provide the information below:

Company name | Face amount | Policy number

3. Health questions

A.

1. Do any of the following apply to you?

A. currently hospitalized, in a nursing facility, confined to a bed, receiving hospice care	○ Y	○ N
B. require use of oxygen for any lung or respiratory disorder	○ Y	○ N
C. have been diagnosed by a medical professional to have an aneurysm that has not been surgically repaired	○ Y	○ N

2. At any time have you been diagnosed or treated by a medical professional or had surgery for any of the following?

A. any condition requiring bone marrow, stem cell, or organ transplant	○ Y	○ N
B. kidney disease requiring dialysis	○ Y	○ N
C. Alzheimer's Disease, dementia, mental incapacity	○ Y	○ N
D. Lou Gehrig's Disease (ALS)	○ Y	○ N
E. a life expectancy of 12 months or less	○ Y	○ N
F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV)	○ Y	○ N

B.

3. Do you have diabetes?

A. diagnosed by a medical professional before age 40	○ Y	○ N
B. in combination with any heart or circulatory disorder diagnosed by a medical professional (excluding high blood pressure)	○ Y	○ N
C. requiring 40 or more units of insulin daily	○ Y	○ N

4. Within the past 12 months, have you been diagnosed or treated by a medical professional or had surgery for any of the following?

A. heart attack, heart valve disorder, heart blockage, stroke or transient ischemic attack (TIA)	○ Y	○ N
B. any lung or respiratory disorder requiring the use of a nebulizer	○ Y	○ N
C. any lung or respiratory disorder and currently use tobacco	○ Y	○ N
D. internal cancer, melanoma, lymphoma, multiple myeloma, leukemia, systemic lupus (SLE)	○ Y	○ N
E. chronic pancreatitis, chronic hepatitis, cirrhosis	○ Y	○ N

5. Within the past 12 months, have you been recommended by a medical professional to have any of the following?

A. treatment or counseling for alcohol or drug abuse	○ Y	○ N
B. test, surgery, treatment or further evaluation that has not been performed or are there any test results pending	○ Y	○ N

C.

6. Within the past 24 months, have you been diagnosed or treated by a medical professional or had surgery for any of the following?

A. aneurysm, heart attack, any circulatory disorder, stroke or transient ischemic attack (TIA)	○ Y	○ N
B. emphysema, chronic obstructive pulmonary disease (COPD)	○ Y	○ N
C. internal cancer, melanoma, leukemia	○ Y	○ N
D. neuromuscular disorder including, but not limited to, cerebral palsy, multiple sclerosis, muscular dystrophy	○ Y	○ N
E. any connective tissue disorder, ulcerative colitis, Crohn's disease	○ Y	○ N

7. At any time, have you been diagnosed or treated by a medical professional or had surgery for any of the following?

A. congestive heart failure, cardiomyopathy, Parkinson's disease	○ Y	○ N
B. any permanent paralysis, amputation caused by disease	○ Y	○ N

8. Are you dependent on a wheelchair or motorized mobility device? ○ Y ○ N

4. Remarks

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.....

.....

5. Privacy notice

.....

Your application and telephone interview are American Continental Insurance Company's primary sources of information in determining whether to provide coverage to you. The Company, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties without authorization from you. Upon written request, we will provide you with the information contained in your file. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures.

6. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

7. Applicant agreement

I hereby apply to American Continental Insurance Company for a policy to be issued in reliance on my answers to the questions in this application. The applicant and agent represent that the applicant has read, or had read to applicant, the completed application, and the applicant understands that any false statements or misrepresentations made in the application may result in loss of coverage under the policy to which this application is a part.

I, the applicant, represent that the statements and answers given in the application are true, complete and correctly recorded to the best of my knowledge and belief. I agree that no insurance shall be in effect until the application has been accepted and approved by the Company and the first full modal premium has been paid. I understand that no insurance agent is authorized to waive any part of any answer on the application, to approve insurability, make or modify any contract or waive any of the Company's rights or requirements.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Applicant signature Date signed

X .....

Owner signature (if not proposed insured)

X .....

Signed in *City and State*

.....

8. Account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Proposed insured's name

▪

Account owner name, if different than proposed insured's

▪

Account owner relationship to proposed insured: ○ Business owned by proposed insured ○ Living trust ○ Employer ○ Power of Attorney ○ Conservator/guardian ○ Family member; specify ▪

Financial institution name

▪

○ Checking ○ Savings

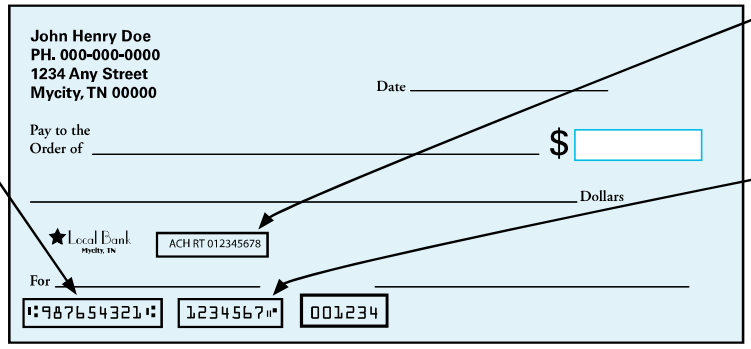
Routing number

▪

Account number

▪

This is an example of a personal check. A business check may be different.



For all other checks, use the nine-character bank **routing number**, which appears between the ⑆ symbols, usually at the bottom left corner of the check.

For checks with an **ACH RT (Automated Clearing House Routing) number**, please use this number.

The **account number** is up to 17 characters long and appears next to the ⑈ symbol at the bottom of the check and usually to the right of the bank routing number.

9. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Signature of account owner Date

X .

10. Agent Statement

I represent the following:

1. That the insurance being applied for is suitable for the owner's insurance needs.
2. I have explained to the applicant the premium mode options.
3. I have provided all required forms on or before the date the application was taken.
4. I have accurately recorded the information supplied by the applicant.

Number 4 is applicable only if agent has personally recorded the information on the application.

Does the proposed insured have any existing life insurance or annuity contracts? ○ Yes ○ No

Will the policy applied for be a replacement or change existing life insurance or an annuity? ○ Yes ○ No

If the answer to either question is "yes", have you complied with the requirements of the Company and your state regarding this replacement? ○ Yes ○ No

The writing number reflects where commissions will be paid.

Agent name *Printed* | Writing number (agent or company)

Agent signature

X

Phone | E-mail

11. Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through American Continental Insurance Company (ACI), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with ACI in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains inforce.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective ACI commission schedule.

Writing agent *Printed* | Percentage %

Secondary agent *Printed* | Writing number | Percentage %

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Writing agent signature

X

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800 264.4000
aetnaseniorproducts.com
office hours 7:30 a.m. - 4:30 p.m. CST

Receipt
from American Continental Insurance Company

- Print clearly and use blue or black ink.
- Applicant keeps this receipt for their records.

Proposed insured's name *Printed*

Date of application

Initial payment collected (if applicable)

$ ◯ Check ◯ Money order

EFT draft amount

$

This acknowledges receipt of your application for an American Continental Insurance Company Whole Life insurance policy.

Agent name *Printed*

Phone

Agent signature

X

- Payment will be refunded for any coverage not issued.
- All premium payments must be made payable to American Continental Insurance Company.
- DO NOT make any check payable to the agent and do not leave the payee blank on the check.
- A recorded interview may be required as part of the underwriting on your application for insurance.

Thank you for choosing American Continental Insurance Company!

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Suite 200
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Authorization To Fax Check
from American Continental Insurance Company

• Print clearly and use blue or black ink.

1. Usage Guidelines

Note: Your checking account may be debited the same day your agent faxes the check to us.

Requirements:

- The faxed check method can only be used for **initial premium payments** when the recurring method of payment will be **electronic funds transfer.** This method cannot be used for a one time direct bill quarterly, semi-annual or annual mode.
- The check must be entirely completed. We will not accept faxed checks with missing information such as: pay to, date, written amount, dollar amount, signature, etc.
- The agent will properly destroy the original check once faxed and received at the Home Office.
- Fax the signed authorization with the application for insurance and required forms to 877 302.3304.

2. Authorization

Your agent will submit your application for insurance and your initial payment request to American Continental Insurance Company via facsimile (fax).

By signing this form, you authorize American Continental Insurance Company to initiate an electronic funds transfer from your bank account according to the terms of the check. This means your check will be converted to an electronic transaction. Your agent will destroy your original check after it is faxed and received at the Home Office.

I hereby authorize American Continental Insurance Company to draw an electronic funds transfer from my checking account to pay for this life insurance policy. Future premiums for this life insurance policy will be deducted from this checking account until you notify us to change your billing.

Applicant signature	Date signed
X	.

(Signature as it appears on bank records)

American Continental Insurance Company

An Aetna Company

800 Crescent Centre Dr. • Suite 200 • Franklin, TN 37067 • 800 264.4000

Authorization for Release of Health-Related Information
This Authorization is intended to comply with the HIPAA Privacy Rule

Name of Proposed Insured/Insured [please print legibly]	Date of Birth
Name of Proposed Insured/Insured [please print legibly]	Date of Birth
Name of Proposed Insured/Insured [please print legibly]	Date of Birth

I, the named person above, authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to American Continental Insurance Company ("ACI") or to its agents, employees, and representatives. This Authorization applies to information about: my past, present, or future physical or mental health or condition; health care I receive; the past, present or future payment for my health care; and any related diagnosis, treatment, or prognosis. This includes, but is not limited to, information about: drugs; tobacco, alcoholism and mental illness; and may be in electronic or paper form. This includes any information regarding the diagnosis or treatment of the Human Immunodeficiency Virus infection and sexually transmitted diseases.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization whatsoever and that I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that ACI may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and/or 5) conduct other legally permissible activities that relate to any coverage that I have or have applied for with ACI.

This Authorization shall remain in force for twenty-four (24) months following the date of my signature below for the purpose of collecting information in connection with my application for insurance, reinstatement of my policy or a change in policy benefits. This authorization shall remain in force for the term of coverage of the policy in connection with a claim for benefits under the policy. A copy of this Authorization is as valid as the original Authorization itself. I understand and agree that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to ACI to the attention of the Underwriting Department at the above address. I understand and agree that a revocation is not effective to the extent that any of My Providers have relied upon this Authorization, or to the extent that ACI has a legal right to contest a claim under an insurance policy or to contest the policy itself since any such revocation may prevent ACI from completing its review of policy claims. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without Authorization by HIPAA and that no action relating to this Authorization shall be construed to create any restriction whatsoever on the uses of my protected health information that HIPAA allows without my Authorization. I understand and agree that any information that is disclosed pursuant to this Authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, ACI will not be able to process my application, or if coverage has been issued, may not be able to process policy claims. I acknowledge that I have received a copy of this Authorization and my authorized representative is also entitled to receive a copy of this form upon request.

Signature of Proposed Insured/Insured	Date	Description of Personal Representative's Authority, if applicable
Signature of Proposed Insured/Insured	Date	Description of Personal Representative's Authority, if applicable
Signature of Proposed Insured/Insured	Date	Description of Personal Representative's Authority, if applicable

TO AGENT: Have Applicant complete and sign front and back of Home Office Copy (White) to submit with application. Give Applicant the Applicant Copy (Yellow).

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Authorization for Release of Health-Related Information
This Authorization is intended to comply with the HIPAA Privacy Rule

Name of Proposed Insured/Insured [please print legibly]	Date of Birth
Name of Proposed Insured/Insured [please print legibly]	Date of Birth
Name of Proposed Insured/Insured [please print legibly]	Date of Birth

I, the named person above, authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to American Continental Insurance Company ("ACI") or to its agents, employees, and representatives. This Authorization applies to information about: my past, present, or future physical or mental health or condition; health care I receive; the past, present or future payment for my health care; and any related diagnosis, treatment, or prognosis. This includes, but is not limited to, information about: drugs; tobacco, alcoholism and mental illness; and may be in electronic or paper form. This includes any information regarding the diagnosis or treatment of the Human Immunodeficiency Virus infection and sexually transmitted diseases.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization whatsoever and that I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that ACI may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and/or 5) conduct other legally permissible activities that relate to any coverage that I have or have applied for with ACI.

This Authorization shall remain in force for twenty-four (24) months following the date of my signature below for the purpose of collecting information in connection with my application for insurance, reinstatement of my policy or a change in policy benefits. This authorization shall remain in force for the term of coverage of the policy in connection with a claim for benefits under the policy. A copy of this Authorization is as valid as the original Authorization itself. I understand and agree that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to ACI to the attention of the Underwriting Department at the above address. I understand and agree that a revocation is not effective to the extent that any of My Providers have relied upon this Authorization, or to the extent that ACI has a legal right to contest a claim under an insurance policy or to contest the policy itself since any such revocation may prevent ACI from completing its review of policy claims. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without Authorization by HIPAA and that no action relating to this Authorization shall be construed to create any restriction whatsoever on the uses of my protected health information that HIPAA allows without my Authorization. I understand and agree that any information that is disclosed pursuant to this Authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, ACI will not be able to process my application, or if coverage has been issued, may not be able to process policy claims. I acknowledge that I have received a copy of this Authorization and my authorized representative is also entitled to receive a copy of this form upon request.

Signature of Proposed Insured/Insured	Date	Description of Personal Representative's Authority, if applicable
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TO AGENT: Have Applicant complete and sign front and back of Home Office Copy (White) to submit with application. Give Applicant the Applicant Copy (Yellow).

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An Aetna Company

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REQUEST FOR INFORMATION
This Request is intended to comply with the HIPAA Privacy Rule

_____ _____
Name of Proposed Insured [Please print legibly] Date of Birth

I UNDERSTAND that American Continental Insurance Company ("ACI") has other products, services or special discounts that are available to me through it and its business partners. To inform me of these offers, I AUTHORIZE ACI to use or disclose collected information about me to itself, its affiliated companies, marketing partners, agents and service providers. ACI may use my information to determine if certain offers would interest me. Such collected information may include: demographic information, including name and address; information about my transactions and experiences with ACI; information received from me regarding health information, income, assets, credit history or other financial information.

I UNDERSTAND that I am not required to sign this Request for Information and if I fail to do so, such failure will not affect my ability to obtain coverage or available benefits. I also understand that if I decide not to sign this Request for Information, it may prevent ACI from advising or disclosing to me of other non-health related services or products which may interest me in the future.

I UNDERSTAND that ACI WILL NOT disclose any medical records received by ACI from my physician or health care provider pursuant to this Request for Information. If ACI does disclose such collected information, it may receive compensation by its marketing partners or other third parties that receive such collected information.

I UNDERSTAND that any such collected information disclosed pursuant to this Request for Information may be subject to re-disclosure by the recipient and no longer protected by the privacy rule under the Health Insurance Portability and Accountability Act.

I UNDERSTAND that this authorization shall remain valid for twenty-four (24) months from the date stated below. I may exercise my right at any time to revoke this authorization by providing written notice to ACI.

I UNDERSTAND that a copy of this Authorization shall be as valid as the original.

_____ _____ _____
Signature of Proposed Insured/Insured Date Description of Personal Representative's Authority, if applicable

_____ _____ _____
Signature of Proposed Insured/Insured Date Description of Personal Representative's Authority, if applicable

_____ _____ _____
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REQUEST FOR INFORMATION
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Name of Proposed Insured [Please print legibly] Date of Birth

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I UNDERSTAND that I am not required to sign this Request for Information and if I fail to do so, such failure will not affect my ability to obtain coverage or available benefits. I also understand that if I decide not to sign this Request for Information, it may prevent ACI from advising or disclosing to me of other non-health related services or products which may interest me in the future.

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IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ____ YES ____NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ____ YES ____NO

If you answered “yes” to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the contract number if available) and whether each policy will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY	# INSURED	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure document must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____	_____	_____
Date	Applicant’s Signature	Applicant’s Printed Name
_____	_____	_____
Date	Producer’s Signature	Producer’s Printed Name

I do not want this notice read aloud to me. _____ (Applicant must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration or how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS: Are they affordable?
Could they change?
You're older - are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES: New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY: If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for anew policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

American Continental Insurance Company

An Aetna Company

800 Crescent Centre Dr., Suite 200 • Franklin, Tennessee 37067 • 800 264.4000

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ____ YES ____NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ____ YES ____NO

If you answered “yes” to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the contract number if available) and whether each policy will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY	# INSURED	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in-force illustration, policy summary or available disclosure document must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____.

I certify that the responses herein are, to the best of my knowledge, accurate:

_____	_____	_____
Date	Applicant’s Signature	Applicant’s Printed Name
_____	_____	_____
Date	Producer’s Signature	Producer’s Printed Name

I do not want this notice read aloud to me. _____ (Applicant must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration or how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS: Are they affordable?
Could they change?
You're older - are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES: New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY: If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for anew policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
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PRODUCER STATEMENT

In connection with a Replacement of Insurance Transaction:
I certify that:

- I have used only American Continental Insurance Company approved sales material
- I have left all sales materials and the Replacement Notice with the applicant, and
- This sale conforms with the company's replacement policy.

The form number(s) of the sales materials left with the applicant are noted below. If no sales materials were used, state "none".

_____ _____

_____ _____

_____ _____

Date: _____

_____
Producer's Signature

_____
Producer's Name

Replacement Policy

We believe that the replacement of an existing life insurance policy must be appropriate for the customer and must meet his or her needs or financial objectives. From a customer's perspective, an appropriate replacement is one that is justified from either an economic or personal standpoint. The costs, provisions, features and benefits of both the current and proposed policy should be considered in relation to the customers needs, circumstances and goals.

Some examples of the types of provisions that should be considered are premium rate differences and differences in suicide and incontestability provisions. In addition, factors such as the age and health of the customer must be considered. Producers are expected to provide all material information that the customer needs in order to ascertain whether replacement of an existing policy or contract is appropriate.

All replacements must be in compliance with applicable regulations and company rules. Many states require accurate written comparisons of existing and proposed contracts be provided to the customer when proposing a replacement. Producers are expected to know and comply with these requirements.